Mutations in POMT1 Are Found in a Minority of Patients With Walker–Warburg Syndrome

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Walker–Warburg syndrome (WWS) is an autosomal recessive disorder of infancy characterized by hydrocephalus, agyria, retinal dysplasia, congenital muscular dystrophy, and over migration of neurons through a disrupted pial surface resulting in leptomeningeal heterotopia. Although previous work identified mutations in the o-mannosyl transferase, POMT1, in 6 out of 30 WWS families [Beltran-Valero de Bernabe et al., 2002], the incidence of POMT1 mutations in WWS is not known. We sequenced the entire coding region of POMT1 in 30 consecutive, unselected patients with classic WWS. Two novel heterozygous mutations were found in two patients from non-consanguineous parents, whereas 28 other patients failed to show any POMT1 mutations. One patient was found to be heterozygous for a transition, g.1233T>A, which predicts p.Y352X. A second patient was found also to be heterozygous for a transition g.1790C>G, which predicts p.S537R. As an additional determination of the g.1233T>A, which predicts POMT1 heterozygosity and negative LOD scores at the POMT1 locus. From these data we show that POMT1 is an uncommon cause of WWS, the incidence of coding region mutations in this population of WWS being less than 7%. We conclude that while the incidence of POMT1 mutations in WWS can be as high as 20% as reported by Beltran-Valero de Bernabe et al. [2002] and it can be as low as ~7%, as reported here. © 2005 Wiley-Liss, Inc.

KEY WORDS: Walker–Warburg syndrome; muscle eye brain; Fukuyama congenital muscular dystrophy; CMD; lissencephaly; POMT1; mannosyl migration; dystroglycan; neuronal migration

INTRODUCTION

Walker–Warburg syndrome (WWS, MIM 236670) is a rare autosomal recessive disorder with developmental malformations of the brain, skeletal muscle, eyes, as well as other abnormalities [Walker, 1942; Warburg, 1978; Dobyns et al., 1985]. Aﬀected infants present with hypotonia, blindness, or with severely diminished vision, severe developmental delay, and death during infancy [Dobyns et al., 1989b]. They suﬀer from congenital muscular dystrophy and congenital ocular abnormalities, which can include microphthalmia, optic nerve hypoplasia, retinal dysplasia, and cuta¬racts [Kuchelmeister et al., 1993; Lavender et al., 1993]. Diagnosis is confirmed by MRI analysis, which reveals severe hydrocephalus, complete loss of cerebral gyration (folding), and cerebellar and brainstem hypoplasia [Barkovich et al., 1991; Cormand et al., 2001]. Approximately one-third of patients have an occipital encephalocele [Dobyns et al., 1989a]. Postmortem examination of the brain in eight cases reveals a cobblestone surface resulting from a large number of undifferentiated neurons migrating through the pial surface, forming leptomeningeal heterotopia in the subarachnoid space [Kimura et al., 1993; Squirer, 1993; Vaisar et al., 2000; Beltran-Valero de Bernabe et al., 2002].

WWS appears to be a genetically heterogeneous disorder with a world-wide distribution [Beltran-Valero de Bernabe et al., 2002]. In a previous study 6 out of 30 unrelated WWS patients were shown to have loss of function mutations in the o-mannosyltransferase, POMT1 [Beltran-Valero de Bernabe et al., 2002]. These results suggest that the frequency of POMT1 mutations in WWS may be as high as 20%. We undertook this study to examine the incidence of POMT1 mutations in a consecutive unselected series of patients with classic WWS.

MATERIALS AND METHODS

Blood and/or DNA was collected from patients for whom the diagnosis of WWS was conﬁrmed by the following criteria: death in early childhood, ocular abnormalities and signs of congenital muscular dystrophy, severe hydrocephalus and type II lissencephaly with global agyria [Dobyns, 1989; Cormand et al., 2001]. Twenty-seven of the thirty patients in this study were reported to have all of these findings as well as one or more of the following: cerebellar hypoplasia (25), brainstem hypoplasia (21), agenesis of the corpus callosum.
(22), agenesis of the septum pellucidum (14), interhemispheric fusion (11), and the presence of an encephalocele (7). One family (family 1) has been described in a previous study [Rodgers et al., 1994].

For three of the thirty patients in this study, clinical data regarding muscular dystrophy was unavailable. For one of these three clinical data for ocular abnormalities had also not been obtained. All three were reported to demonstrate severe hydrocephalus, type II lissencephaly with global agyria, and a hypoplastic cerebellum. Two of these three were reported to have agenesis of the corpus callosum and the third, a hypoplastic brainstem. Together, these CNS abnormalities are specific to WWS and thus confirm the diagnosis of WWS in these three patients.

WWS patients in this study included people of Asian, African, and Caucasian descent. Consanguineous families studied were from South Carolina, USA (family 1), Israel (family 2), Saudi Arabia (family 3), Mexico (family 4 and 5), and the United Arab Emirates (family 6) (Fig. 1). Eight of the thirty WWS patients used in this study may have been analyzed for mutations in POMT1 in part or fully by Beltran-Valero de Bernabe et al. [2002]. However, we have re-sequenced all of these in this study because (1) we are uncertain whether POMT1 gene sequencing had been completed in these samples and (2) including them provided a consecutive series of unselected WWS patients that allows for more accurate data about incidence.

Informed consent was obtained from all patients and/or their parents, in accordance with protocols approved by the institutional review boards of Beth Israel Deaconess Medical Center, Boston Children's Hospital, local institutions, and the Office of Human Research Protection. Genomic DNA was extracted from peripheral blood lymphocytes using standard techniques. For the affected patients from family 1, DNA was extracted from paraffin-embedded brain tissue using the corresponding Qiagen QIAamp DNA mini kit and protocol.

Amplification and analysis of fluorescently labeled microsatellite markers were performed using standard methods. The following markers D9S290, D9S752, D9S1861, D9S1863, D9S179, D9S1830, and D9S164, all within less than 4 cM from the POMT1, were analyzed for homozygosity. Primer sequences and conditions were obtained from the UCSC genome database (July 03 version), and are available upon request. Multipoint LOD scores were calculated using GeneHunter [Daly et al., 1998]. We assumed a susceptibility allele with frequency 0.001 and a recessive mode of inheritance with penetrance 0.999. The most current Marshfield map was used to determine distances between markers. For each marker, four equal alleles were assumed. However, the use of different allele frequencies and susceptibility allele frequencies did not significantly alter the final results.

Primers for all 19 coding exons of POMT1 were designed to amplify exon sequences as well as 50 base pairs of adjacent intron sequences. Primers and sequences are available on request. Over 100 base pairs of both the 3' and the 5' UTR were also sequenced and analyzed. Amplicons generated were purified using Princeton Separation columns. Amplicons were then sequenced in both directions using an ABI3700 capillary.
sequencer (Perkin Elmer Applied Biosystems, Foster City, CA). Sequence data were analyzed independently by two separate individuals.

RESULTS

Thirty non-selected, non-related WWS patients with clinical findings typical of WWS were used for this study. In each of these patients, the coding region of POMT1 was then sequenced and analyzed both in the forward and reverse directions. Twenty-eight of the 30 patients (93.3%) failed to reveal any mutations in POMT1. Two novel mutations were identified in two patients from non-consanguineous families. The first patient (whom we will refer to as patient 7) is a Caucasian girl from Iowa. She was reported to have congenital muscular dystrophy, extremely elevated creatin kinase (39,650 U/L), optic atrophy, retinal dysplasia, and non-attachment. MRI analysis revealed complete agyria, kinking of the cervical medullary junction, and Dandy–Walker malformation with severe obstructive hydrocephalus involving the lateral and third ventricles. She suffered from seizures, poor coordination, had a poor sucking reflex, and difficulties swallowing, resulting in an inability to feed. She also had congenital contractures of her right wrists.

Patient 7 was found to be heterozygous for a genomic transition, g.1233T > A, which is predicted to result in p.Y352X (Fig. 1A). A stop codon at tyrosine 352 in exon 11 is then predicted to result in truncation in more than half of the POMT1 protein and the loss of several conserved mannosyltransferase IP2R and RyR domains (MIR) thought to be involved in ligand transfer (Fig. 1C). Sequencing of the coding regions of POMT1 revealed only one mutation in this patient. We assume that Patient 7 is a compound heterozygote for a second mutation not in the coding region of POMT1.

The second patient (whom we will refer to as Patient 8) is a Caucasian boy also from the United States. He was a dysmorphic neonate with microcephaly, a sloping forehead, small eyes, microgathria with intact lips, low set ears, and undescended testicles. Patient 8 suffered from severe seizures, poor growth, and no spontaneous respiration, requiring a ventilator. Ocular abnormalities included retinal dysplasia and anterior chamber defects. He was reported to have agyria with ventriculomegaly and Dandy–Walker malformation.

Patient 8 was found to be heterozygous for a genomic transition, g.1790C > G, which is predicted to cause the replacement of a conserved serine 537 by an arginine. Although it is outside of any recognized domains, serine 537 is in a large central hydrophilic stretch [Jurado et al., 1999] (Fig. 1C). Around this region POMT1 is otherwise composed of 7–12 transmembrane domains, which make up more than half of the protein length.

Our inability to find a second mutation in these two patients is not uncommon for other recessive disorders [Taniguchi et al., 2003], but points to the possibility of mutations in the non-coding regions of POMT1. Mutations occurring in the promoter or non-coding regions cannot be ruled out in any of the patients from non-consanguineous patients. However, although non-coding mutations might explain a small number of cases, the fact that our patients from consanguineous families failed to show linkage to POMT1 makes it unlikely that non-coding mutations in POMT1 are a major cause of WWS. In addition, most patients with the closely related disorder, muscle eye brain (MEB) disease, have been found to have mutations within coding exons of the causal gene POMGnT1 [Yoshida et al., 2001; Taniguchi et al., 2003].

DISCUSSION

Here we sequenced POMT1 in 30 consecutive WWS patients and found two that are heterozygous for g.1790C > G (predicted p.S537R) and g.1233T > A (predicted p.Y352X) changes. These changes are likely to be mutations for the following reasons. First, sequencing of 110 control subjects failed to identify either of these same changes. Second, p.Y352X is predicted to result in severe truncation of more than half of the POMT1 protein and p.S537R is predicted to result in the replacement of a conserved serine with a positively charged arginine. Although it is outside of any recognized domains, serine 537 is in a large central hydrophilic stretch [Jurado et al., 1999] (Fig. 1C). Around this region POMT1 is otherwise composed of 7–12 transmembrane domains, which make up more than half of the protein length.

In addition to these two likely mutations, a total of six sequence alterations were identified in seven different patients, as listed in Table I. Two of these are silent changes that do not alter amino acids, and the other four are known single nucleotide polymorphisms and are thus also assumed to be non-pathogenic.

Six of the WWS patients showed consanguineous parents (Fig. 2) and therefore were informative enough to obtain linkage information. Analysis of seven consecutive microsatellite markers within 4 cM of the POMT1 locus at 9q34.1 ruled out linkage to the POMT1 locus in all six consanguineous families (Figs. 2 and 3). None of the consanguineous families showed identity by descent at the POMT1 locus (Fig. 2) and all the LOD scores were negative (Fig. 3). This suggests that in these six families, neither coding nor non-coding mutations in POMT1 are responsible for WWS.

TABLE I. Single Nucleotide Polymorphisms of POMT1

<table>
<thead>
<tr>
<th>Patient number</th>
<th>Location</th>
<th>Nucleotide</th>
<th>Amino acid</th>
<th>Allele frequency</th>
<th>Referenceb</th>
</tr>
</thead>
<tbody>
<tr>
<td>19, 28</td>
<td>Exon 8</td>
<td>930C &gt; T</td>
<td>R251W</td>
<td>16.7%</td>
<td>rs3887873</td>
</tr>
<tr>
<td>8, 33, 41a</td>
<td>Exon 8</td>
<td>931G &gt; A</td>
<td>R251Q</td>
<td>16.7%</td>
<td>rs2926949</td>
</tr>
<tr>
<td>8, 33, 41a</td>
<td>Exon 10</td>
<td>1121C &gt; C/T</td>
<td>Silent T314T</td>
<td>16.7%</td>
<td>—</td>
</tr>
<tr>
<td>33, 41</td>
<td>Exon 10</td>
<td>1158G &gt; G/A</td>
<td>V327I</td>
<td>10%</td>
<td>rs4740164</td>
</tr>
<tr>
<td>8, 33, 41</td>
<td>Exon 11</td>
<td>1292C &gt; C/T</td>
<td>Silent D371D</td>
<td>16.7%</td>
<td>rs3794949</td>
</tr>
<tr>
<td>25, 30</td>
<td>Exon 17</td>
<td>1957G &gt; A</td>
<td>Silent R586R</td>
<td>10%</td>
<td>—</td>
</tr>
</tbody>
</table>

Nucleotide number is based on the POMT1 reference sequence (GeneBank Accession Number NM_00717).

aNucleotide alterations found in the heterozygous state. All others were homozygous.

bReferenced in NCBI SNP Cluster Report.
Our results suggest that mutations in POMT1 represent a small subset of WWS patients (just under 7% assuming the patients with heterozygous mutations carry second mutations as well). In a previous study, five novel mutations in POMT1 were identified in six unrelated families [Beltran-Valero de Bernabe et al., 2002]. The families with POMT1 mutations were from various regions of Europe including Italy, Holland, Austria, and Turkey. Thus, the mutations found were not from a specific geographic region nor did they appear to represent a specific founder mutation. Our own WWS patients derive from a broad range of geographical and ethnic origins and include many of European ancestry. Hence, geographic selection is an unlikely explanation for the apparent low frequency of POMT1 mutations in our patients.

The difference in POMT1 mutation frequency in this study and the previous study [Beltran-Valero de Bernabe et al., 2002] could be due to clinical differences in the WWS populations selected for sequencing. However, the criteria we used for diagnosis of WWS in our study closely resembles those described in the previous publication. In addition, a second study has identified a deletion in POMT1 in a Japanese boy with a slightly atypical presentation of WWS suggesting that POMT1 mutated WWS patients can have a broad range of phenotypes [Kim et al., 2004]. A detailed clinical and radiologic comparison between WWS patients with and without POMT1 mutations are needed in order to determine that how these two groups of WWS patients might differ.

In conclusion, our data confirm the presence of POMT1 mutations in WWS patients, but suggest that, in our patient population, POMT1 mutations cause a small fraction of the cases and that the predominant gene or genes that cause WWS remain unidentified. We conclude that while the incidence of POMT1 mutations in WWS can be as high as 20% as reported by Beltran-Valero de Bernabe et al. [2002] and it can also be as low as ~7%, as reported here. Although DNA based sequencing may be useful in limited settings, families and physicians seeking testing for POMT1 mutations should be cautioned of the potential low return of DNA based sequencing for diagnostic purposes.

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